Date:
Patient Name
Patient Address

Dear Mr. / Ms…:

Thank you for taking the time to reach out to us at HOSPITAL and share your experience. We here at HOSPITAL take comments, complaints, and compliments seriously and hope this response satisfies your expectations. (Perhaps include a statement such as, "We are sorry your stay here at HOSPITAL did not meet your standards.)

In your letter to us, you shared some concerns. The fact finding included WHOMEVER WAS INTERVIEWED, DOCUMENTS REVIEWED, ETC. The following outlines HOSPITAL's review of the concerns you shared:

- Complaint in Patient's words… Hospital review… Finding
- Next Complaint in Patient's words… Hospital review… Finding
- Next Complaint in Patient's words… Hospital review… Finding

If you are dissatisfied with the results of this review, please be advised that you have the right to request that HOSPITAL reconsider this decision. To do so, you must put your request in writing within ten (10) days of the receipt of the attached decision and send it to:

Name of Person in Charge
Hospital Name
Hospital Address

Per 104 CMR 32.04(7), any party to the complaint has the right to request reconsideration of this decision. The parties must request reconsideration in writing within ten (10) days of receipt of the decision. The request must, with specificity, assert:

- the failure to interview an essential witness or the failure to consider an important fact or factor;
- that the decision is not reasonably supported by the facts; or
- that the decision is based on an erroneous interpretation of applicable law or policy.

Reconsideration requests should be sent to:

Janet E. Ross, MS, RN
Assistant Commissioner for CPS/Director of Licensing
Department of Mental Health
25 Staniford Street
Boston, MA 02114

In addition to a reconsideration request, the client, a Legally Authorized Representative, or an individual or entity authorized to act on behalf of the client may appeal to the Commissioner of the Department of Mental Health under 104 CMR 32.04(7)(b)3b. The Commissioner's decision shall be final. All appeals must be submitted in writing within ten (10) days of receipt of the decision. Appeals should be completed on the enclosed appeal form and be sent to:

Commissioner
Department of Mental Health
25 Staniford Street
Boston, MA 02114

If you have any questions on any of these rights as explained above, or would like an appeal form, please call the Human Rights Officer, (NAME OF HRO) at (HRO'S PHONE NUMBER).

Sincerely,
NAME OF PERSON IN CHARGE
NAME OF HOSPITAL
cc: HRO